INTEGRATING COLORECTAL CANCER SCREENING WITH CHRONIC DISEASE PROGRAMS
CDC RFA DP09-903
Pre-application Technical Assistance Conference Calls
February 17–18, 2009

SUMMARY OF QUESTIONS AND ANSWERS

Key Dates

Letter of Intent Deadline: March 11, 2009

Application Deadline: April 10, 2009

Estimated Award Date: June 30, 2009

Funding Levels, Funding Categories and Use of Funds

QUESTION: Is there a predetermined amount of funds available for each program component within this funding announcement (e.g., screening, data collection.)? Is there a required proportion of funds that should be used for the clinical versus nonclinical components of this colorectal cancer program, similar to the 60%:40% clinical to nonclinical funding allocation required in the National Breast and Cervical Cancer Early Detection Program?
ANSWER: There are no predetermined funding amounts for the specific program components within this funding announcement and there is no requirement for a predetermined proportion of funds to be allocated towards clinical vs. nonclinical services.

QUESTION: Are there any special requirements for applicants for the Surveillance component?
ANSWER: As described in the Funding Opportunity Announcement (FOA) on page 21,, applicants applying under the funding category of Surveillance of Publicly Funded (Colorectal Cancer) CRC Screening Programs should demonstrate a minimum of two years, from the award date, of implementing a population-based, publicly-funded (CRC) screening program on a state-, tribal-, or territorial-wide basis. Preference will be given to programs that have screened more than 800 persons during the most recent 12-month period for which data are available.

QUESTION: Will CDC give funding preference to states where CRC burden is high?
ANSWER: No.

QUESTION: Will CDC fund support services like patient navigation and transportation for patients?
ANSWER: As described in the FOA on page 14, patient support services like patient navigation and organization of transportation can be supported by CDC funds. CDC funds can be used for transportation costs.

QUESTION: Will more funds be available in future years?
ANSWER: CDC receives an annual budget and plans for level funding annually.

QUESTION: Will CDC reimburse for the indirect rates of subcontractors of the awardee?
ANSWER: Program funds may be used for administrative costs and indirect rates, including amounts applied to subcontracts.

QUESTION: In a setting of flat funding for each year of the program, how should programs budget, particularly if the first year includes 6 months of start-up activities and 6 months of screening?
ANSWER: CDC cannot predict its annual budget/funding allocation for this program. Applicants should submit an annual budget to reflect activities outlined in their work plans.

QUESTION: Will the previously funded Colorectal Cancer Screening Demonstration Program (CRCSDP) sites be given funding preference under this announcement?
ANSWER: This is an open and competitive application process and CDC will make awards based on the application criteria as described in the FOA. However, as described in the FOA on page 47, the following factors may affect funding decisions:

- Maintaining geographic diversity.
- Maintaining diversity in priority subpopulations.
- States that collaborate with tribal organizations in geographic or cultural proximity for the purpose of maximizing the scope of benefit of the program.
- If funds were received in the past for the Colorectal Cancer Screening Demonstration Program and demonstrated—
    - Success in meeting the program standards and screening goals.
    - Effectively spent funds awarded for CRCSDP activities during the budget period.

QUESTION: Is a state with preexisting state funding for CRC screening eligible to apply under this program announcement for funds to augment screening?
ANSWER: Yes, CDC funds can be used to augment screening already being funded with state or other nonfederal monies. Supplanting (replacing) existing nonfederal or federal funds with funds from this new program is not allowable.

QUESTION: Could a state that currently is using state funds to support CRC screening apply for CDC funds under this new award to use for screening, and move the state screening funds to instead cover treatment of persons diagnosed with colorectal cancer through the CDC-funded program?

ANSWER: No. This example constitutes the supplanting of funds, which is not allowable.

QUESTION: Please clarify what CDC means by not using new funds to supplant existing funds, particularly as this relates to other nonfederal funds that are currently anticipated but not in hand?
ANSWER: Supplanting, or replacing, existing nonfederally funded program efforts with funds from this federal award is not allowable. CDC funds can not be used to supplant current or future state funds.

QUESTION: In our state, most people are insured but the reimbursement rate is so low that most providers will not accept it. Can CDC funds be used to increase the reimbursement rate for insured patients as a provider incentive to screen more people?
ANSWER: CDC funds may be used to reimburse for procedures up to, but not above, the local Medicare rate. Funds from this new award could be used to increase current reimbursement rates up to but not above the local Medicare rate.

Integration of Funds

QUESTION: If a state already has some CRC funds as part of their Comprehensive Cancer Control (CCC) award, is it a requirement that funds for this new award be integrated with program activities funded under the CCC funds?
ANSWER: No it is not.

Eligible Applicants

QUESTION: How can the U.S. Army participate in this program to benefit its soldiers and personnel?
ANSWER: The U.S. Army, or other branches of the Department of Defense may collaborate with awarded programs. This screening program is for a low-income, under and uninsured priority population, typically 200% to 250% of the *Federal Poverty Guidelines*, and as described in the FOA on page 18, eligible applicants can apply for this funding opportunity are listed below:

- Federally recognized Indian tribes, tribal organizations, and urban Indian organizations.
- State health departments or their Bona Fide Agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the National Government of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau).

State-wide Screening

QUESTION: Are programs required to provide screening "statewide" within the period of this 5-year program?
ANSWER: No. An applicant must, however, specify the geographic area that will be served, and develop an infrastructure for broad, statewide screening.

QUESTION: Can an applicant propose to use CDC funds to implement a screening program in geographic areas not currently covered by a state-funded CRC screening program; such as, to augment or expand an existing program?
ANSWER: Yes.

QUESTION: Can an applicant propose to begin screening in a smaller geographic area within a state and then expand screening geographically during the 5-year project period?
ANSWER: Yes.

QUESTION: If start up is expected in 6 months, should initial screening goals be more limited, compared to future years' screening projections when screening would take place during a 12-month period?
ANSWER: Yes, that would be acceptable.

Patient Eligibility and Priority Population

QUESTION: How is "average risk" defined for patients?
ANSWER: For the current demonstration screening program, we defined average risk as those persons who had no symptoms suggestive of gastrointestinal disease, no personal or family history of colorectal polyps or cancer, no inflammatory bowel disease, and no evidence of genetic syndromes associated with colorectal cancer. These patients were eligible for screening within the current program. Persons eligible for surveillance were also offered services for the program, which included persons with a personal history of polyps or colorectal cancer. Programs, in conjunction with their Medical Advisory Boards (MABs), made individual determinations of eligibility whether clients with family history of colorectal cancer were considered average or high risk, and whether they were eligible for screening in the program. Four of the five programs offered services to patients with family history of colorectal cancer. Patients with high risk conditions including inflammatory bowel disease and certain genetic syndromes were not eligible for the program. Similar eligibility criteria will be used under this new award.

QUESTION: Our program has an existing MAB that uses different eligibility criteria than the Colorectal Cancer Screening Demonstration Program. If we receive CDC funding, can we use our own MAB's client eligibility criteria?
ANSWER: No. For services provided with CDC funds, your program would be required to use the eligibility criteria defined by CDC, unless where clearly specified that the local MAB and the program should define eligibility.

QUESTION: Why are people with gastrointestinal symptoms, inflammatory bowel disease, or genetic syndromes associated with developing colon cancer ineligible for screening under this program?
ANSWER: Symptomatic persons, and those with the conditions described in the question above, require a medical evaluation or ongoing disease management that is outside the scope of the activities described in this award, and would be ineligible in this program.

QUESTION: Do patients have to be enrolled with a primary care provider prior to being screened by this program?
ANSWER: As described in the FOA on page 7, applicants should collaborate with health care delivery systems that serve the priority population to assure that patients are currently enrolled with a primary care provider prior to receiving services through this program. Primary care services and networks vary across states and communities. Enrollment in community health clinics meets this requirement. A program that enrolls a patient for primary care services for screening under this program must meet this requirement.

QUESTION: Are Native Americans with Indian Health Service (IHS) health coverage eligible for screening under this program?
ANSWER: Yes, Native Americans with IHS coverage that are otherwise eligible based on income, risk status, etc. may be screened by this program. By federal regulation, IHS is the payer of last resort for Native Americans, so funds under this new program would be used before IHS funds. This is consistent with the National Breast and Cervical Cancer Early Detection Program practices and policies.

QUESTION: Does the eligible population include those at 200% or 250% of the *Federal Poverty Guidelines* (*FPG*)? And will the program be evaluated based on reaching the population at 200% of the *FPG* level?
ANSWER: Applicants will define the low income population they intend to reach. CDC will measure the reach of each program based on a population which is 200% of the *FPG*. As described in the FOA on page 7, the program priority population is persons aged 50–64 years, asymptomatic, and at average risk for CRC, with inadequate or no health insurance for CRC screening, and are low-income, typically at 200% or 250% of the *FPG*.. Regardless of the *FPG* level chosen by the awardee, CDC will evaluate program activities based on reaching the population at 200% of the *FPG* level.

Reimbursable Services

QUESTION: Will CDC reimburse costs for a separate prescreening an office visit with a health care provider?
ANSWER: Yes.

QUESTION: Will CDC reimburse for diagnostic colonoscopies?
ANSWER: Yes, if the initial screening was performed by the program. CDC will reimburse for approved CRC screening tests, tests performed for diagnostic follow up of initial screening tests, and test performed for surveillance of previously detected colorectal polyps or cancers. CDC will not reimburse for procedures to stage disease or for cancer treatment (e.g., radiation, chemotherapy).

QUESTION: What is the reimbursement rate for clinical services?
ANSWER: CDC will reimburse up to the local Medicare or lower negotiated rate. A listing of current (CPT) codes that CDC reimburses as part of the CRCSDP program is available in the policies and procedures manual on the (CRCSDP) Web site. http://www.cdc.gov/cancer/colorectal/what_cdc_is_doing/demonstration/

QUESTION: Will CDC reimburse for facility fees?
ANSWER: Yes. A listing of current CPT codes that CDC reimburses as part of the CRCSDP program is available in the policies and procedures manual on the CRCSDP Web site.
http://www.cdc.gov/cancer/colorectal/what_cdc_is_doing/demonstration/.

Screening and Recruitment

QUESTION: How does CDC define an organized CRC screening program?
ANSWER: An organized screening program should include all program components outlined in the funding announcement (e.g., program management, screening and diagnostic follow-up services, public education and client recruitment, quality assurance and professional development, partnership development and maintenance, clinical and cost data collection and tracking, patient support services, program monitoring, and evaluation).

QUESTION: Please clarify what is meant by being clinically evaluated before an endoscopic procedure? Does this evaluation need to be completed in person? Do they need to be evaluated by a doctor?
ANSWER: Patients must be clinically evaluated prior to receiving an endoscopic procedure. This could be conducted by telephone or in-person, and should be conducted by a physician or a nurse, as determined by the program and their MAB.

QUESTION: Can local health departments be involved in recruiting and referring patients to the screening program?
ANSWER: Yes.

Treatment of Cancer or Complications of Screening Procedures

QUESTION: How firm should the commitment for treatment resources be?
ANSWER: As described in the FOA, applicants must ensure that non-CDC resources (e.g., private funds or other public funding) are in place to support treatment for persons diagnosed with cancer through the program and those experiencing medical complications from screening and diagnostic procedures.
This is described in the FOA on pages 6, 8, 9, 14, 20, 29, 41, and 45.

QUESTION: How is CDC addressing the treatment provision for persons diagnosed with cancer through this program? What efforts is CDC undertaking at this time regarding legislation?
ANSWER: CDC recognizes the critical importance of the issue of securing treatment resources. However, this issue of federal efforts to address treatment resources is outside the scope of this FOA.

QUESTION: What information is available to inform planning for treatment costs? Can we contact the current demonstration screening programs?

ANSWER: This information can be obtained from several CDC publications documenting the start-up period of the demonstration screening programs, or from the current CRCSDP programs contact page. http://www.cdc.gov/cancer/colorectal/what_cdc_is_doing/demonstration/.

Data Collection and Tracking – CCDEs/ Cost data

QUESTION: Will CDC provide software for clinical data collection similar to CaST?
~~**ANSWER:** No, states will utilize their own datasystem.~~
ANSWER: CDC is exploring the possibility of supporting a data management system like CaST. The decision to support such a system will be made at the time of awards under this new program.

QUESTION: Will the CCDEs be revised or are they final?
ANSWER: As described in the FOA on page 13, the CCDEs will be modified for this program in an effort to reduce the burden on awardees.

QUESTION: What types of cost data will be required?
ANSWER: Two types of cost data will be collected, the Cost Assessment Tool (CAT) and program reimbursement data (PRD). The purpose of the CAT is to collect data on costs related to start-up activities and program implementation. Information will be collected on costs associated with staff salaries, screening and diagnostic tests, outreach efforts, quality assurance, database management, and other activities performed by the programs. Information will also be collected on in-kind contributions (e.g., donated labor and other resources).

The purpose of the PRD is to estimate the clinical costs incurred. Data, such as billing codes (Current Procedural Terminology (CPT), Ambulatory Payment Classification (APC), Healthcare Common Procedural Coding System (HCPCS)), reimbursement amounts, patient ID and date of procedure, will be collected from the office visits and for screening and diagnostic procedures funded through the program.

Application

QUESTION: Should the work plan address the 5-year project period?
ANSWER: Applicants should include one-year and 5-year program objectives in their work plan as well as annual screening projections for each of the five years. Specific activities and strategies planned for the first budget period should be included in the work plan.

QUESTION: Can the work plan be single spaced?
ANSWER: Yes

QUESTION: What parts of the application are included in the 27-page limit?
ANSWER: The application content, structure, and page limit for each section is fully described in the FOA starting on page 22, in section **IV.2. Content and Form of Submission.**

Program Policies

QUESTION: Will CDC use the same or similar program policies currently used for the Colorectal Cancer Screening Demonstration Program?
ANSWER: As described in the FOA on page 15 under the CDC activities in this program, CDC will establish program policies and guidelines collaboratively with awardees after awards are made.

Reporting Requirements

QUESTION: What is the difference between the interim progress report due 90 days before the end of each budget period and the annual program report due 90 days after the end of each budget period?
ANSWER: The interim progress report is a report which includes proposed activities and objectives for the upcoming new budget period. The annual progress report due 90 days after the budget period should describe the program's progress through the full 12-month budget period.